Healing Point, LLC

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Patient Health History

Please complete this questionnaire as thoroughly as possible - the information will greatly aid your practitioner. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient's physical, mental and emotional states. Print all information and indicate areas of confusion with a question mark. Along with all your medical information, this form will be kept completely confidential. Thank you.

Date: _____/_____/_____

Name: _____ _____ _____
(first) (middle initial) (last)

Date of Birth: _____/_____/_____ Age: _____ Gender: M / F

Address: _____ City, State, Zip: _____

Home Phone: _____ Mobile: _____ Work: _____

May we contact you by phone and leave a message if necessary? Y / N If yes, at which phone #? _____

Email Address: _____ May we email you appointment reminders? Y / N

May we email you quarterly updates and info about classes & events? Y / N

Do you have a: Partner? Y / N Spouse? Y / N Have you been widowed? Y / N

Do you have children? Y / N If so, what are their ages? _____

Emergency Contact's Name, Phone #, and relationship to you: _____

Educational Background: _____ Occupation: _____

Employer: _____ Hours of work per week: _____

Do you enjoy work? Y / N Why or why not? _____

Please rate your current stress level (circle): low medium high

What are your primary sources of stress? _____

Have you experienced any major traumas (ie abuse, major accidents, homelessness, death of spouse/partner, etc)? Y / N

If so, please describe: _____

_____

Interests and hobbies: _____

When are you happiest?: _____

How did you hear about us? _____

Can we thank someone for referring you? _____

When and where have you recently received health care [with any type of practitioner(s)]

_____

For what reason did you receive health care? _____

Are your current health concerns the result of: an automobile accident? Y / N a work-related injury? Y / N

Has your case been referred to an attorney? Y / N

Please identify below the health concerns that have brought you to the Healing Point Clinic (in order of importance):

Condition **Past Treatment**

1. _____

How does this condition affect you? _____

2. _____

How does this condition affect you? _____

3. _____

How does this condition affect you? _____

4. _____

How does this condition affect you? _____

Please list any medications (prescribed and/or over-the-counter), vitamins, herbs, and/or supplements you are currently taking (including dosages):

_____

_____

_____

History of Hospitalizations and Surgeries:

Reason	When	Reason	When
_____		_____	
_____		_____	
_____		_____	

Family History (Check all that are applicable):

	Father	Mother	Sibling(s)	Grandparents	Children	Spouse/Partner
Age (if living)						
Age at death						
Cause of Death						
Health (G)good, (P)poor						
Cancer (specify type)						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						
Asthma or Allergies						
Kidney Disease						
Liver Disease						
Endocrine Disorder (thyroid, etc)						
Gastrointestinal Disorder						
Arthritis						
Other						

Your Height: _____ Current Weight: _____ Past Maximum Weight: _____ When? _____

What is your most recent blood pressure reading? _____/_____ When was this reading taken? _____

Do you have any infectious diseases? Y / N If yes, please list: _____

Childhood Illness (please circle any that you have had): Scarlet Fever Diphtheria Rheumatic Fever Mumps

Measles German Measles Chicken Pox Other(s): _____

Immunizations (please circle any that you have had): Polio Tetanus Measles/Mumps/Rubella Pertussis

Diphtheria Hib Hepatitis B Chicken Pox Other(s):_____

Please list any foods, drugs, or substances you are hypersensitive or allergic to (please include reaction): _____

_____

_____

For the following sections, please **circle** any symptoms or illnesses you experience **now** and underline any that you have experienced in the past:

Mental/Emotional: Mood Swings Nervousness/Anxiety Mental Tension Depression Phobias Panic Attacks Bi-Polar Disorder Obsessive Compulsive Disorder Schizophrenia Post Traumatic Stress Disorder (PTSD) Other(s): _____

Energy and Immunity: Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome Frequent Colds/Flu Other(s): _____

Skin: Dry or Oily Skin Itching Rashes Hives Eczema Psoriasis Acne Unusual or Excessive Sweating Other(s): _____

Head, Eye, Ear, Nose, and Throat: Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems Hay Fever/Allergies Frequent Nasal Congestion Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Other(s): _____

Musculoskeletal: Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Leg Pain Upper Back Pain Mid Back Pain Low Back Pain Sensation of Heaviness in Limbs Joint Pain (if so, where?): _____ Other(s): _____

Neurological: Vertigo/Dizziness Paralysis Numbness/Tingling Muscle Weakness Loss of Balance Stroke Poor Memory Seizures/Epilepsy Multiple Sclerosis Other(s): _____

Respiratory: Pneumonia Chronic Cough Difficulty Breathing Emphysema Pleurisy Asthma Tuberculosis Shortness of Breath Other(s): _____

Cardiovascular: Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Palpitations/Fluttering Heart Attack Heart Murmurs Rheumatic Fever Varicose Veins Other(s): _____

Gastrointestinal: Ulcers Changes in Appetite Nausea/Vomiting Abdominal Pain Frequent Passing of Gas Heartburn Frequent Belching Gall Bladder Disease Liver Disease Hepatitis B or C Jaundice Hemorrhoids Bloating Diarrhea Constipation Blood or Mucus in Stool Undigested Food in Stool Fatigue After Eating High Cholesterol Other(s): _____

Endocrine: Hypothyroid Hyperthyroid Hypoglycemia Diabetes Unusual Sensations of Hot or Cold Cold Hands and/or Feet Night Sweats Other(s): _____

For the following sections, please **circle** any symptoms or illnesses you experience **now** and underline any that you have experienced in the past):

Urinary: Kidney Disease or Stones Painful Urination Frequent Urination Impaired Urination Blood in Urine

Frequent Urination at Night Frequent Urinary Tract Infections (UTI) Incontinence Other(s): _____

Male Reproductive: Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

Sexually Transmitted Disease(s) Other(s): _____

Female Reproductive/Breasts: Irregular Cycles Heavy Flow Bleeding Between Cycles Painful Periods

Premenstrual Problems/Symptoms Menopausal Symptoms Vaginal Dryness Unusual Vaginal Discharge

Breast Lumps Breast Tenderness Nipple Discharge Difficulty Conceiving Endometriosis

Sexually Transmitted Disease(s) Other(s): _____

Do you have **any** reason to believe you may be pregnant? Y / N If yes, how far along are you? _____
(Please remember to inform your practitioner in the future if you have any reason to believe you might be pregnant.)

Age of First Menses: _____ Average # of Days of Menses Flow: _____ Length of Cycle (between flows): _____

Birth Control Use – Current and in Past (if applicable): _____

If applicable: # of Pregnancies: _____ # of Live Births: _____ # of Miscarriages: _____ # of Abortions: _____

Any complications during pregnancy, birth and/or postpartum? _____

Other: Anemia or Other Blood Disorders Cancer Fibromyalgia Sensation of "Foggy" or "Heavy" Head

Eating Disorder(s) Lyme's Disease Problems with teeth and/or gums Other(s): _____

_____

Is there anything else we should know (including other symptoms not listed above)? _____

_____

_____

Lifestyle:

Number of meals eaten per day: _____ Number of snacks eaten per day: _____

Types and amount of beverages per day: _____

For the following substances please indicate types and average amount of current and/or past use (if applicable):

Caffeine: _____

Nicotine: _____

Alcohol: _____

Recreational Drugs: _____

Type(s) and amount(s) of exercise each week: _____

_____

Religious and/or spiritual practice: _____

Average hours of sleep per night _____ Do you wake rested? Y / N

Any problems falling asleep or staying asleep? Y / N If so, please describe: _____

Anything else you would like us to know: _____

Thank you for taking the time to fill out this form.
It will greatly help us to assess and treat you in our clinic.